

Registration District No. 5

Primary Registration District No. 5-029

Registrar's No.

## 1. PLACE OF DEATH:

(a) County. Atchison  
 (b) City or town. Rural Lincoln  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. (Specify whether

In this community. 2 years  
years, months or days)3. (a) PRINT FULL NAME Allison Woodard3. (b) If veteran,  
name war.3. (c) Social Security  
No.

4. Sex. Male 5. Color or race. Wh  
 6. (a) Single, widowed, married, divorced. Married  
 6. (b) Name of husband or wife. Emily M Woodard  
 6. (c) Age of husband or wife if alive. 80 years

7. Birth date of deceased. Aug-16-1855  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
87 5 4 hr. min.

9. Birthplace. Illinois  
 (City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name. David Woodard  
 13. Birthplace. Illinois  
 (City, town, or county) (State or foreign country)

14. Maiden name. Ellen Clark  
 15. Birthplace. Illinois  
 (City, town, or county) (State or foreign country)

16. (a) Informant. John Richardson  
 (b) Address. Blanchard, Iowa

17. (a) Removal (b) Date thereof. Jan-22-43  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Blanchard Cemetery

18. (a) Signature of funeral director. Scott  
 (b) Address. Westboro, Missouri

19. (a) (Date received local registrar) (b) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County. Atchison  
 (c) City or town. Rural  
 (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
 If yes, name country.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21st  
 year 1943 hour 10 minute A M.

21. I hereby certify that I attended the deceased from Dec. 1st 1942 to Jan. 21 1943  
 that I last saw him alive on Jan 21st, 1943  
 and that death occurred on the date and hour stated above.

Immediate cause of death. Coronary Disease of the Heart  
 Duration Several  
years

Due to.

Due to.

Other conditions. 94 a  
 (Include pregnancy within 3 months of death)

Major findings:

Of operations.

Of autopsy.

## PHYSICIAN

Underline  
 the cause to  
 which death  
 should be  
 charged sta-  
 tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).

(b) Date of occurrence.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)  
 While at work? (z) Means of injury.

23. Signature. Edward Luke (M. D. or other)Address Coin, Iowa Date signed 1-25-42

ENC B1VC

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Scott Tucker

Registered Apprentice No. 2824

working under my personal supervision.

Signed.....

*Scott Tucker*

Licensed Embalmer No. 2824

P. O. Address Westvoro, Missouri

**Note:** The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. *m.e*

Registration District No. *5*

Primary Registration District No. *5029*

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County *Atchison*  
(b) City or town *Rural*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME *Allison Woodard*

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex *M* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *M*

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased *Aug 16 1918*  
(Month) (Day) (Year)

8. AGE: Years *87* Months *5* Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) *Feb 12 1943* (b) *(Signature)*  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Jan* day *2*  
year *1943* hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

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